



Site Monitoring Report of

Southwest Behavioral Health Center

Local Authority Contracts #152258 and #152259

Review Dates: April 18th, 2017

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Southwest Behavioral Health Center (also referred to in this report as SBHC or the Center) on April 18th, 2017. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	6 - 7
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 3	11 - 13
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	14 - 15
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	20

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of Southwest Behavioral Health Center (SBHC). The Governance and Fiscal Oversight section of the review was conducted on April 18th, 2017 by Chad Carter, Auditor IV and Kyle Larson, Administrative Services Director. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Client fees were reviewed for consistency and adherence to approved fee schedules. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and/or the contracted County.

As part of the site visit, the most recent version of the Medicaid Cost Report was reviewed. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter.

The CPA firm Hafen Buckner Everett & Graff performed the Center's financial statement audit for the year ending June 30th, 2016 and issued a report dated October 17th, 2016. The auditors issued an unqualified opinion that the financial statements present fairly, in all material respects, the respective financial position of Southwest Behavioral Health Center. No findings or deficiencies were identified.

Follow-up from Fiscal Year 2016 Audit:

No findings were issued in FY16

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) Southwest Behavioral Health Center's client cost for Substance Abuse Treatment is above the state average client cost in the same area. DSAMH Division Directives state, "The Local

Authority shall meet an overall client cost within fifty (50) percent of the statewide Local Authority overall average cost per client and with-in twenty-five (25) percent of their previous year actual cost per client.” The average Local Authority client cost for Substance Abuse Treatment in the State of Utah is \$3,555. Southwest Behavioral Health Center’s client cost in this area is \$6,234, which is 75.4% over the statewide average and above the range provided in the Division Directives of 50% of the statewide average. Please provide a justification for the higher cost per client.

Center’s Response and Corrective Action Plan:

Response: Southwest Behavioral Health Center is committed to the provision of quality care in an efficient and effective manner. Current SBHC Substance Use Disorder treatment programming has been developed based on the local needs of the five-county area. Included in that continuum of care are evaluation services, outpatient care, intensive outpatient care (IOP), and residential services. Over its long history, SBHC has operated and maintained 3 SUD Residential Treatment programs. These programs were created to address a significant demand for SUD residential services in an area where few, if any, options were available in the past. The fixed costs associated with these programs (uniquely including overnight staff, and brick and mortar expenses, etc...), as well as the finite number of clients that can be served in any given year, significantly impact SBHC’s cost per client when compared to other agencies that do not manage residential treatment programming. Add to these residential cost factors that SBHC’s clients tend to stay in treatment longer than in other areas of the State, and the impact is magnified in the disparity in our comparable costs, as our denominator of “clients served” would be smaller by comparison. We believe that these factors impact considerably the overall cost per client for SBHC.

Plan: SBHC is not currently planning to add any additional residential programs, but will continue, throughout the fiscal year, to explore contractual options with public and private partners for available residential beds. SBHC will support any efforts by the State to remove barriers created by the antiquated IMD rules, precluding the viability of some private residential programs. SBHC’s current subcontracting model demonstrates our commitment to utilizing more cost effective treatment options when appropriate. SBHC will also continue to review ongoing research into the most effective levels of care, comparing outcomes of Outpatient, IOP and residential programming. As subcontracted residential options become available, perhaps SBHC will eventually be able to step back from some fixed costs associated with current programming.

FY17 Deficiencies:

None

FY17 Recommendations:

None

FY17 Division Comments:

- 1) FY17 Division Directives require that each Local Authority conduct a walk-through testing of their adherence to access standards prior to their scheduled site visit. SBHC completed their walk-through before the site visit and discussed the results in the opening meeting for

the site visit. The results of the walk-through were positive and showed that all minimum access standards were being met. The testers were happy with the time it took to go through the process and with the facilities. Suggested areas of improvement included the parking area and better signage.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Southwest Behavioral Health Center on April 17th, 18th, and 19th, 2017. The monitoring team consisted of Eric Tadehara, Program Administrator; Tiesha Cohen, Program Manager; and Laura Adams, Family Mentor with the Utah Family Coalition (Allies with Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, program visits, and feedback from families through questionnaires. During the visit, the monitoring team reviewed FY16 audit findings and County responses; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention funding; civil commitment; compliance with Division Directives; and the Center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2016 Audit

FY16 Deficiencies:

- 1) *Medication Management:* SBHC did not provide medication management at a rate similar to the state (22.6%) or rural (14.3%) averages.

This deficiency has been resolved; SBHC continues to increase the number of youth medication management is provided to and works closely with the community providers to ensure children and youth are provided appropriate services.

- 2) *Juvenile Civil Commitment:* SBHC was not using up to date Civil Commitment forms.

SBHC is utilizing up to date forms, but there are still forms missing from the juvenile civil commitment process. This deficiency has not been resolved; see deficiency #1.

- 3) *Youth Outcome Questionnaire:* The Youth Outcome Questionnaire (YOQ) was not being administered at the required frequency.

SBHC has made progress, but it has not been resolved and will continue as a deficiency; see deficiency #3.

- 4) *Multi-Agency Coordinating Committees (MACCs):* SBHC was not fully participating in multi-agency coordinating committees throughout their catchment area.

This deficiency has been resolved as evidenced by FY17 records review, meetings with clinical administration, and meetings with community partners.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

None

FY17 Deficiencies:

- 1) *Juvenile Civil Commitment:* SBHC is not completing the Notice of Discharge From Commitment forms. Civil Commitment paperwork for juveniles needs to be completed consistent with State statute 62A-15-703 utilizing the proper forms for children's civil commitment procedures located on the DSAMH website at <http://dsamh.utah.gov/provider-information/civil-commitment/>.

Center's Response and Corrective Action Plan:

SBHC has taken and will take the following actions to correct the process for completing Notice of Discharge From Commitment Forms:

1. Link to the Division's Notice of Discharge Form built in to Credible on 7/28/17
2. Date field called 'Anticipated Discharge Date for Youth' was added on 7/28/17 to the Commitment Tracker that is built in to SBHC's EHR (Credible) and is currently being used for tracking all commitments.
3. Mechanism added in Credible on 7/28/17 so that the Date field (described above) will trigger an e-mail to the staff person doing the commitment tracking (for any particular client) notifying them that the anticipated discharge date has arrived and that a Commitment Discharge form must be completed.
4. Date field called 'Commitment Discharge for Youth Completed' was added on 7/28/17 where the person completing the Commitment Tracker can indicate the date the Commitment Discharge form was completed.
5. Periodic reports will be run by the Data Manager to confirm that there are Commitment Discharge for Youth Form has been entered for all youth who have been discharged from Commitment.

- 2) *Recovery Plan Objectives:* Recovery plan objectives were a recommendation in FY16. During the FY17 chart review, objectives in five of eleven of the charts were vague, lacked meaning for children, youth, and families, and were difficult for a child or youth to achieve. Examples include: client "will use DBT skills to manage her anxiety" and "Foster mother will practice prompting Client in ways she can use her words to get her needs met." Division Directives require that objectives be "measureable, achievable, meaningful and within a timeframe."

Center's Response and Corrective Action Plan:

Recovery Plan

SBHC believes that the term ‘Objective’ has become overused in such a way that in spite of efforts to define it as very discreet actions, some staff continue to consider it referring to a non-specific goal. SBHC will continue a focus on refining ‘Objectives’ by substituting that term with the term ‘Action’. In addition SBHC will train youth teams again on writing Actions that are measureable, achievable, meaningful and within a timeframe.

1. The following process will be completed by **August 31, 2017**
 - a. 4 charts of each PSC selected at random by the Records Specialist and audited using the Actions audit tool.
 - b. Audit report is given to each PSC.
 - c. PSC reviews the audit, signs and forwards to Program Manager
 - d. Program manager and PSC review the audits where improvement is needed.
 - e. Program managers review audits with Clinical Director
2. The process above (#4) will be completed **each month** thereafter.
3. Program Managers will use weekly team meetings to review Actions and include:
 - a. Identification of an ‘Awesome Action’ of the week.’
 - b. Report of the percent of reviewed records that entirely met the audit standard.
 - c. Lead discussion on how to improve objectives.
4. Each month the Clinical Leadership Team (Program Managers, QI Chair, and Clinical Director) will review overall percentage of audit reports to determine if expected improvement in objectives is being made. If not meeting expected improvement, Corrective Action Plan will be modified.

Goal: By **December 31, 2017**: 90% of all audited Actions will entirely meet audit standards.

- 3) *Youth Outcome Questionnaires*: The YOQ is not being administered at the required frequency. Division Directives state “DSAMH will require that the Youth Outcome Questionnaire (OQ/YOQ) be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).” It is recognized that SBHC has made progress from FY16 in increased the frequency the YOQ is administered. Through records reviews, four of the charts reviewed had YOQs that were not administered at the required frequency of at least once every 30 days. It is recommended that SBHC continue to improve the administration frequency for youth who are eligible for the YOQ.

Center’s Response and Corrective Action Plan:

During part of the year the link that directly opened the OQ Report within our EHR was not working; this resulted in staff not following-up or reviewing the reports due to the more cumbersome process of having to login to another system. This has been resolved.

Increasing Administration and Reviews of OQ/YOQ

1. The Data Manager will run two monthly reports, beginning 8/14/2017
 - a. Percentage of open clients who have had completed an OQ/YOQ in the last 30 days.
 - b. Percentage of each clinician’s caseload that have reviewed and OQ/YOQ in the last 30 days.
2. Beginning 9/1/17, Program Managers will review report ‘a’ with office managers each

month to determine progress and set goals for improvement in giving OQ/YOQs to clients each month

3. Beginning 9/1/17, Program Managers will review report 'b' with each clinician each month to determine progress and set goals for improvement in reviewing OQ/YOQs with clients each month.
4. Beginning 9/1/17, the Clinical Director will review results of both reports with each Program Manager each month to determine progress and set improvement goals.

FY17 Recommendations:

None

FY17 Division Comments:

- 1) *Community Involvement:* SBHC continues to provide services throughout the community. SBHC provides therapeutic and medication management services to the New Hope Program. SBHC has begun to participate in multi-agency coordination meetings throughout the five county catchment area and continues to provide supports to other agencies, including System of Care.
- 2) *School-Based Services:* SBHC provides school-based behavioral health (SBBH) services in over 40 schools in the catchment area. In FY16, SBHC provided 301 children and youth school-based services. SBHC continues to extend their school-based mental health services throughout the community, including into more schools with high rates of intergenerational poverty.
- 3) *Family Feedback:* The Utah Family Coalition (UFC) gathered family feedback from 34 questionnaires completed by families in Iron County and Washington County. Overall, families believe SBHC staff are "great" and that they "inform those served on everything they need to know." It was noted that most families are grateful for the services they receive.
- 4) *Wraparound & Family Resource Facilitators:* Through review it was found that SBHC is providing Wraparound to fidelity as defined by the UFC in Iron and Washington Counties. The Family Resource Facilitators (FRF) are integral parts of the team and the service delivery system in both counties. It is recommended that SBHC look for opportunities to clarify the role of the FRF and to better educate on the purpose and need of family voice.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of Southwest Behavioral Health Center on April 18th and 19th, 2017. The team included Pam Bennett, Adult Program Administrator, LeAnne Huff, Adult Mental Health Program Manager, Cami Roundy, Recovery and Resiliency Peer Program Manager and Pete Caldwell, Assisted Outpatient Treatment Program Manager. The review included the following areas: Discussions with clinical supervisors and management teams, record reviews, site visits to administrative offices, Switchpoint homeless shelter, Mountain View Residential housing, Cedar City Jail, and the Kanab outpatient office. During the discussions, the team reviewed the FY16 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2016 Audit

FY16 Minor Non-compliance Issues:

- 1) *Documentation of Outpatient Services:* A review of documentation demonstrated that six out of eleven (55.0%) charts did not have a current assessment update. In addition, six out of eleven (55%) included progress notes that did not contain a plan, reaction of the client to the intervention, or information to assess any progress toward goals and objectives. Six out of eleven (55%) did not have measurable objectives. The Division Directives state that objectives should be "behavioral changes that are measurable, short term and tied to the goals."

This finding has been resolved: Chart views for FY17 contained updated assessments, treatment plans and had measurable objectives.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

- 1) *Outcome Questionnaire (OQ) Administration/ and as an Intervention:* The Division Directives require at least 50% of the adults served have a valid administration each fiscal year, and that the OQ be administered every 30 days or every visit (whichever is less) for each consumer of the Local Mental Health Authorities. The FY17 score card shows SBCH rate has dropped from 53.8% in FY16 to 41.6% in FY17, which is below the required rate. In addition the Division Directives require that data from the OQ shall be shared with the client and incorporated into the clinical process, as evidenced in the chart. The use of the OQ

as an intervention was only evident in one of ten charts reviewed. Appropriate use of the OQ as an intervention has been demonstrated to improve treatment outcomes. DSAMH recommends SBHC increase their OQ administration rate to the required 50%, and utilize the OQ as an intervention tool with the client as evidenced by documentation in the progress notes.

Center's Response and Corrective Action Plan:

During part of the year the link that directly opened the OQ Report within our EHR was not working; this resulted in staff not following-up or reviewing the reports due to the more cumbersome process of having to login to another system. This has been resolved.

Increasing Administration and Reviews of OQ/YOQ

1. The Data Manager will run two monthly reports, beginning 8/14/2017
 - a. Percentage of open clients who have had completed an OQ/YOQ in the last 30 days.
 - b. Percentage of each clinician's caseload that have reviewed and OQ/YOQ in the last 30 days.
2. Beginning 9/1/17, Program Managers will review report 'a' with office managers each month to determine progress and set goals for improvement in giving OQ/YOQs to clients each month
3. Beginning 9/1/17, Program Managers will review report 'b' with each clinician each month to determine progress and set goals for improvement in reviewing OQ/YOQs with clients each month.
4. Beginning 9/1/17, the Clinical Director will review results of both reports with each Program Manager each month to determine progress and set improvement goals.

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *Inpatient Services:* The FY16 Mental Health Scorecard shows SBHC with the highest percentage of inpatient services as compared to other rural local mental health authorities in the State. DSAMH recognizes and appreciates the efforts SBHC has made to address the high inpatient numbers and the impact that a temporary closing of the Dixie Regional Access Center may have had. It is recommended that SBHC continue to use practices such as Dialectic Behavior Therapy phone coaching, and to collaborate with community partners, to help divert individuals from inpatient care and stabilize them in the community.

FY17 Division Comments:

- 1) *Homeless Services:* DSAMH appreciates SBHC and Switchpoint's dedication to providing shelter and other needed services to individuals experiencing homelessness. In addition to shelter, Switchpoint has a large food pantry that provides food to individuals and families who meet the requirements for this benefit. In addition, they have a kitchen that provided breakfast and dinner to those staying at the shelter. Switchpoint has developed a system where individuals who are homeless can volunteer in their large garden area, washroom, around the campus as well as in a new dog boarding and day care program called Bed and

Biscuits. Through volunteering they find meaning, and they can exchange the work they do for needed belongings. They have also provided a space for pets so having a pet is not a barrier to staying at the shelter.

- 2) *Mountain View Residential (MVR):* DSAMH recognize and appreciate the great services being provided at MVR where clients can transition out of the State Hospital or come into the center to stabilize during a crisis. They are able to assess readiness for discharge based on how they manage their adult daily living skills. MVR has a kitchen where they have the opportunity to prepare their own meals as well as eat with a larger group and attend day treatment during the day to continue working on skill development.
- 3) *Community partners:* DSAMH appreciates the positive working relationship SBHC has with its community partners including the Piute Indian Tribe. The Piute Tribe has fully integrated their behavioral health and physical health services, including electronic medical record and waiting room area. SBHC and representatives from the Piute Tribe sit on regular community meetings, sharing information and collaboration on community needs.
- 4) *Participant Feedback:* DSAMH Recovery and Resiliency Peer Program Manager, Cami Roundy, met with a group of five individuals at the Elev8 program and seven individuals at Oasis House in Cedar City. Ten of twelve individuals expressed that their treatment is going very well and that they are progressing. Two of the individuals said that they are doing fairly well and making slow progress. All agreed that they choose their own goals, and one of the members has received his CPSS and is also going to college. Seven of the members said that they have received help with employment, all have help with transportation as needed, and six have also had help with housing. All participants indicated that they have been offered Tobacco Cessation. Quotes from individuals in the program include; “I like the program and like coming every day”, “I am going to school and getting ready to get a job”, “They make really good meals here, and I really like helping out in the kitchen”, and “The surroundings are a comfortable place to be.”
- 5) *Peer Support Specialist Program:* DSAMH Recovery and Resiliency Peer Program Manager, Cami Roundy, met with Peer Specialists from SBHC. DSAMH appreciates the way SBHC integrates and promotes their Certified Peer Support Specialists (CPSS), and commends their ongoing support of CPSS in Utah through facilitation of monthly CPSS support calls. Eight of twelve participants interviewed said that they receive Peer Support, know that they can call them when they need help. They expressed appreciation for the CPSS, who help them to meet their goals and get them involved, and meet with them one on one as needed. Comments included; “My Peer Support Specialist is someone I can talk to and someone who understands me” and “Peer Support helps me to be in a good mood and remember my appointments.”

Substance Abuse Prevention

Susannah Burt, Program Manager, conducted the annual prevention review for Southwest Behavioral Health on April 14th, 2017. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the reviews evaluated the services described in the annual prevention area plan and evaluated the data used to establish prevention priorities.

Follow-up from Fiscal Year 2016 Audit

FY16 Deficiencies:

- 1) There was a decrease in the number of Eliminating Alcohol Sales to Youth. For the year, only 42 checks were completed in the LSAA. This is a decrease from 77 the previous year.

This deficiency has been resolved. There was an increase in the number of EASY compliance checks for FY16.

Findings for Fiscal Year 2017 Audit

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

None

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) It is recommended that SBHC works toward submitting discretionary grant tasks in a timely manner.

FY17 Division Comments:

- 1) SBHC demonstrated a knowledge and understanding of trends by preparing a thorough presentation for the site visit.
- 2) SBHC requires all staff and providers to follow program curriculum, including pre and post tests for all programming. This is monitored by observation as well as checklists.

- 3) SBHC has a strategic plan for the LSAA that incorporates the Action Plans from the coalitions in the five counties. Each strategic plan includes action plans for each year.
- 4) SBHC reported that they support seven community coalitions throughout the LSAA; five of the coalitions have youth coalition components. This is an increase over the past 12 months.
- 5) SBHC supports the coalitions' efforts to assess, build capacity, plan, implement and evaluate evidenced by providing staff time to assist with each step and promoting the successes of each coalition.

Substance Abuse Treatment

Christine Simonette, Program Manager and Thomas Dunford, Program Manager, conducted the review of Southwest Behavioral Health on April 18th, 2017. The review focused on compliance with State and Federal law, DSAMH contract requirements and DSAMH Directives. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to Drug Court, Justice Reinvestment Initiative (JRI) and the Drug Offender Reform Act (DORA) requirements and contract requirements were evaluated by a review of policies and procedures, clinical records and through interviews with Southwest Behavioral staff. Treatment schedules, policies, and other documentation were also viewed. The Utah Substance Use Disorder Treatment Outcomes Measures Scorecard results were reviewed with staff. Client satisfaction was measured by reviewing records, Consumer Satisfaction Survey data and results from client interviews. Finally, additional data was reviewed for Opiate Use, Suicides, and Driving Under the Influence (*DUI*) rates for Washington, Iron, Garfield, Kane, and Beaver Counties.

Follow-up from Fiscal Year 2016 Audit

FY16 Minor Non-compliance issues:

- 1) The FY15 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Increased Alcohol Abstinence rates for SBHC were 26.4% which fell below 75% of the National average, which is the DSAMH minimum standard.

This issue has been resolved. SBHC raised their Alcohol Abstinence from 26.4% to 43%.

- 2) The FY15 Utah Substance Abuse Treatment Outcomes Measures Scorecard reflects that Decreased Criminal Justice Involvement rates for SBHC were 20.6% which is below 75% of the National average, the DSAMH minimum standard.

This issue has not been resolved and will be continued in FY17; see Minor Non-compliance Issue #1.

- 3) *Tobacco Cessation:* Division Directives state the Local Substance Abuse Authorities will show that the percent of clients who use tobacco will decrease from admission to discharge by 5%. For SBHC in FY15, the rate of cessation fell from 6.3% to -1.3%. It is recommended that SBHCs initial approach to tobacco cessation as part of overall wellness be re-energized and reinforced.

This issue has been resolved. SBHC has decreased the percentage of individuals using tobacco at time of discharge.

Findings for Fiscal Year 2017 Audit:

FY17 Major Non-compliance Issues:

None

FY17 Significant Non-compliance Issues:

None

FY17 Minor Non-compliance Issues:

1) The Utah Substance Abuse Treatment Outcomes Measures Scorecard showed:

- The percent of individuals that completed a treatment episode successfully decreased from 45.5% to 41.6%, from FY15 to FY16 respectively, which does not meet Division Directives.
- The percentage of decreased criminal involvement from FY16 to FY17 went from 20.6% to 0%, which does not meet the minimum Division standards..

Center's Response and Corrective Action Plan:

Treatment Episode Successfully completed

SBHC notes that most of the Local Authorities had very similar drops in scores as those reported by SBHC. This therefore appears to be a systemic issue, statewide. SBHC will work with the other Clinical Directors to identify a root cause for this trend and collaborate on solutions.

Decreased Criminal Involvement

SBHC has determined that the 0% is due to a reporting error. Subsequent data gathering demonstrates that decreased criminal involvement went from 20.6% (FY16) to an estimated 36% (FY17). We found that our data mapping mechanism within our Electronic Health Record was not properly mapping the updated/correct information for State Reporting. We are making these adjustments to our EHR and will have this completed by July 31, 2017.

We have also found that a number of clinical staff are not updating this reporting element regularly. We will be making this a required question, meaning clinical staff will have to regularly update this reporting element before completing documentation. This change to clinical workflow will be completed by August 12, 2017.

FY17 Deficiencies:

None

FY17 Recommendations:

- 1) *The National Alliance for Buprenorphine Treatment (NAABT)*: DSAMH recommends additional training for staff on language that furthers public understanding of addictive disorders as a medical issue to reduce stigma and stereotyping. One excellent resource that could be distributed to staff can be found at: https://www.naabt.org/documents/NAABT_Language.pdf. Another excellent resource

can be found online at: <https://www.whitehouse.gov/ondcp/changing-the-language-draft>. DSAMH is available to provide technical assistance upon request.

- 2) There is no written policy and procedure for on-site drug testing given to clients for their review or records. It is recommended that a policy and procedures document be written and a hard copy be given to all clients at intake or as soon as possible thereafter. Per FY16 Division Directives, section C, subcategory vii, it is stated as follows:
 - c. *Required Written Policy and Procedures: All DSAMH programs, contractors, subcontractors and providers who perform drug testing shall have written policies and procedures that address:*
 1. *Selection of participants to be tested (hereinafter participants)*
 2. *Frequency of testing*
 3. *Screening and confirmation methodologies*
 4. *Collection and handling of specimens*
 5. *Procedure for verifying integrity of sample that includes checks for tampering, adulteration and dilution*
 6. *Chain of custody procedures*
 7. *Documentation standards*
 8. *Training requirements for all direct service staff that includes training on principles of trauma informed care*
 9. *Disclosure of results or other information related to drug screen participation*
 10. *Potential consequences for testing positive*
 11. *The participant's right to request confirmation testing*
 12. *Procedures to ensure the physical and emotional safety of staff and participants*
 13. *All policies and procedures are subject to review and approval by the Department of Human Services (DHS)*
- 3) SBHC is currently only providing regular criminogenic screens for individuals involved in drug court. DSAMH reviewed R523-4 with SBHC and emphasized that all justice involved individuals need to have carcinogenic screen. It is recommended that SBHC implement a protocol to obtain from the referring sources or administer an evidence based criminogenic screen on all justice involved clients.
- 4) While discussing the method used to identify and count persons who are justice involved, it was found that SBHC might not be identifying everyone who fit into this statistic. It is recommended that SBHC review protocols and practices used to obtain information about an individual's involvement in the justice system to determine if they are "compelled" into services or not.

FY17 Division Comments:

- 1) SBHC has paid for a therapist to be trained in Advanced Tobacco Cessation.
- 2) SBHC has been teaming up with Brookstone, a local Opioid treatment program (OTP) to use as a referral source for opioid addictions, and strengthened the relationship even more by

paying for a couple of Brookstone staff to attend a national Medication Assisted Treatment (MAT) conference.

- 3) SBHC been increasing emphasis on MAT system wide. Three efforts of note are:
 - Providing Vivitrol treatment in the jail to help discharging persons with an opioid use disorder become more successful upon release;
 - Providing instruction and disbursing Naloxone kits to families; and
 - Providing Naloxone kits to St. George PD, and having a confirmed overdose reversal within 24 hours after the initial disbursement.
- 4) SBHC is working close with the OB Hospital in St. George to identify and treat high risk women.
- 5) SBHC has implemented a men's recovery group in Washington County that meets regularly.
- 6) SBHC is trying to bridge the housing issues by using Recovery Support Service funds to help supplement living arrangements for client in recovery.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Southwest Behavioral Health Center and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health


Prepared by:

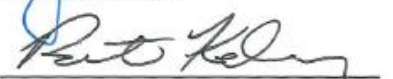
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Auditor IV

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